Part 5: Application and Start of Waiver Services

Sections 5.1 – 5.8

Section 5.1: Request for Application

An individual or his/her guardian may apply for the Development Disabilities, Autism, and/or Support Services Medicaid waiver programs through the local Bureau of Developmental Disabilities Services (BDDS) office. Individuals (or their guardians) have the right to apply without questions or delay.

To apply for the Developmental Disabilities, Autism or Support Services Waiver(s), the individual or guardian must complete, sign, and date an Application for Long Term Care Services (State Form 4594) including the time of day that the application is signed. An individual who has not already applied for waiver services may also need to complete, sign, and date a DDRS Referral and Application (State Form 10057) located at http://www.in.gov/fssa/ddrs/3349.htm . Other individual or agency representatives may assist the individual or guardian in completing the application form and forward it to the BDDS office service the county in which the individual currently resides. The application may be submitted in person, by mail or by fax.

Upon receiving the waiver application, the BDDS staff must contact the individual and/or his/her guardian and discuss the process for determining eligibility for the waiver (documentation of a developmental disability, diagnosis within the Autism Spectrum for the Autism Waiver, Medicaid eligibility, and level of care). If the applicant is not a Medicaid recipient, he/she will be referred to the local Division of Family Resources to apply for Medicaid.

Section 5.2: Medicaid Eligibility: How to Apply for Medicaid

To apply for Medicaid, you will need to fill out and submit an application.

The Medicaid eligibility guide (http://member.indianamedicaid.com/am-i-eligible/eligibility-guide.aspx) will help you determine which application form you will need to fill out and submit.

Once you submit your complete application, it will take about 45-90 days to determine if you are eligible.

Applications for Medicaid, Food Stamps, and Cash Assistance are processed by the Family and Social Services Administration (FSSA), Division of Family Resources (DFR). Indiana is changing the way people apply for benefits. The application process depends on where you live. If you live in a county operating under the "Hybrid" or "modernized" system you can begin to apply on the internet, over the phone, or in your local DFR office. If you live in a non-modernized county you can go to your local DFR office.

DFR office Locations

To find a DFR office near you, visit the DFR website at www.in.gov/fssa/dfr/2999.htm. Scroll down the screen until you see the map and the list of counties. From that list, click on your county of residence.

Online application

To apply online, visit the Family and Social Services Administration site at www.in.gov/fssa/ click on "Apply For Benefits."

Information Required to Complete Medicaid Application

For all the people in your household you will need to know:

- Names and dates of birth
- Social Security Number
- Income from jobs or training
- Benefits you get now (or got in the past) such as Social Security, Supplemental Security Income (SSI), veteran's benefits, child support
- Amount of money in your checking account, savings accounts or other resources you own.
- Monthly rent, mortgage payment and utility bills
- Payments for adult or child care Health coverage and/or medical benefits you currently have
- Go to the Family and Social Services Administration web site to get the specific application instructions based on your county of residence.

Applicants *must* submit the Plan of Care/Cost Comparison Budget (CCB) approval letter (described under Section 5.7 of this manual) to the Division of Family and Children (DFR) when submitting an application for Medicaid benefits or when requesting for a change of Medicaid Aid Category in order to qualify for waiver eligibility.

NOTE: Medicaid eligibility is required prior to the start of waiver services.

Section 5.3: Initial Level of Care Evaluation

An individual targeted for the Developmental Disabilities, Support Services or Autism Waivers must meet the level of care required for placement in an Intermediate Care Facility for the Mentally Retarded or Developmentally Disabled (ICF/MR). In addition, if applying for the Autism Waiver, an individual must have a diagnosis within the Autism Spectrum to be eligible for services through the Autism Waiver.

Initial Level of Care evaluations for these waivers are performed by the Bureau of Developmental Disabilities Services (BDDS) Service Coordinator or a designated contractor, with the following exceptions:

- the individual targeted for waiver services is age five (5) or younger, or
- the individual is currently a resident of an ICF/MR facility and has been cited by the Indiana State
  Department of Health as being inappropriately placed, indicating a violation of a federal standard

Under these exceptions, the level of care determination is made by the DDRS Central Office.

Reevaluations are performed by the contracting entity of case management services.

Qualifications of Individuals Performing Initial Evaluation: Only individuals (contracted staff or state employees) who are Qualified Mental Retardation Professionals (QMRP) as specified by the standard within 42 CFR 483.430(a) may perform initial Level of Care determinations.

Level of Care Criteria: If collateral records are not available or are not a valid reflection of the individual, additional assessments may be obtained from contracted psychologists, physicians, nurses and licensed social workers. Following review of the collateral records, the Developmental Disabilities Profile (DDP) is completed, applicable to individuals with intellectual disability and other related conditions, in order to ascertain if the individual meets ICF/MR LOC.

The DDP assessment tool is used to identify and record:

- vocational programs of applicant/participant
- all developmental disabilities applicable to the applicant/participant as well as any psychiatric diagnosis and results of the individual's intellectual assessment
- status of hearing and vision
- any alleged perpetration of crimes committed by the applicant/participant as well as the need for police involvement for maladaptive behaviors

- barriers which hinder the achievement of personal independence, productivity, integration and community inclusion as well as barriers which hinder achieving the identified lifestyle and related needs
- significant medical conditions requiring specialized medical supports or impacting the participation in services
- utilization and frequency of health-related services including the identification and detailing of issues within the respiratory, cardiovascular, gastro-intestinal and genito-urinary systems, and any evidence of neoplastic or neurological diseases
- seizures by type, frequency and required medications
- medication support needs and medical consequences related to the above conditions
- mobility issues, motor control, cognitive and communication abilities
- the frequency and consequences of behaviors
- self care and activities of daily living support needs
- the need for and frequency of utilization of clinical services

The BDDS Service Coordinator, LOC contractor (initial LOC) or contracting Case Manager (re-evaluations) reviews the DDP and collateral material, applicable to individuals with intellectual disability*, developmental disability and other related conditions, in order to ascertain if the individual meets ICF/MR LOC. An applicant/participant must meet three of six substantial functional limitations and each of four basic conditions (listed below) in order to meet LOC.

The basic conditions are:

- intellectual disability, cerebral palsy, epilepsy, autism, or condition similar to intellectual disability,
- the condition identified in #1 is expected to continue,
- the condition identified in #1 had an age of onset prior to age 22, and
- the applicant needs a combination or sequence of services.

The substantial functional limitation categories, as defined in 42 CFR 435.1009, are:

- self-care,
- learning,
- self direction,
- capacity for independent living,
- receptive and expressive language, and
- mobility.

*Intellectual disability is also known as mental retardation

Section 5.4: Waiting List

It is the policy of the Bureau of Developmental Disabilities Services (BDDS) that individuals may be placed on a waiting list after applying for waiver services and meeting specified criteria. Individuals are responsible for maintaining current collateral and contact information with their local BDDS office.

Initial Placement on Home and Community Based Services Waiver Waiting List(s)

- Individuals or their legal representative must complete an application and submit the application to their local BDDS office to apply for HCBS waiver services.
- Individual is expected to complete the following:
    - Application
    - Collateral Information, including the following:
        - Development Disabilities Profile (DDP)
        - Supporting documents:
            - Diagnostic Evaluation(s)
            - Functional Evaluation(s)
            - Psychological Report(s)
            - Individualized Education Program from schools
            - School records
            - Physician diagnosis and remarks
            - Existing evaluation done by Supplemental Security Income or Vocational Rehabilitation
            - IQ testing done at any time
    - Medicaid application for individuals over eighteen (18) years of age
    - Supplemental Security Income application, if applicable
- A DDP will be used to assess any individual six (6) years of age and older.
- An individual must meet:
    - the State definition of a developmental disability found in IC 12-7-2-61(a); and
    - Intermediate Care Facility for the Mentally Retarded (ICF/MR) Level of Care (LOC) found in 42 CFR §435.1009.
- If an individual completes the application and meets the LOC criteria listed in Section 5.3 above, they will be placed on the waiting list using the individual's application date.

Waiting List Targeting for a Waiver Slot

- Individuals will be targeted for a waiver slot from the statewide waiting list using the individual's application date.
- Individuals will be targeted in the order they applied for services, from the oldest date of application to newest.

Responsibilities of Individuals on the Waiting List

- An individual, or an individual's legal representative, is expected to maintain current contact information with their local BDDS office. This shall include any change in address or telephone number.
- If BDDS attempts to contact an individual or the individual's legal guardian and the identified secondary contact person and is unable to make contact by mail or telephone, the individual may be removed from the waiting list.

Children under the Age of Six (6)

- A parent or guardian may apply for Home and Community Based Services (HCBS) at any time after a child's birth.
- Children under the age of six (6) years old will have their information input into the BDDS database along with date of application.
- Once a child turns six (6) years old, families will have two (2) years to come into their local BDDS office and complete a DDP.
- If upon the child's eighth (8th) birthday a DDP has not been completed, the child will lose his/her original application date.
- It is the family's responsibility to ensure that the local BDDS office receives adequate information to complete the DDP within the timeframe.
- If the child's DDP is completed by the age of eight (8) and BDDS determines that the child meets the criteria for HCBS waiver services, the child will be placed on the waiting list with <u>their original application date</u>.

<u>Section 5.5: Targeting Process</u>

When a slot becomes available, an individual on the waiting list will receive a letter from BDDS Central Office, asking them to accept or decline the waiver slot, apply for Medicaid if he/she hasn't already, and provide or obtain confirmation of their diagnosis from a physician on the DDRS form known as the 450B. A response accepting or declining the waiver slot must be received within 30 days.

If an individual declines placement, his or her name is removed from the waiting list.

If an individual accepts placement:

- An intake meeting at the local BDDS District Office is scheduled to complete the following:
    - Collateral information, provided by the individual, is reviewed and level of care, again, established

    - DDP is completed
    - ICAP is ordered
    - Allocation is recorded into system
- The individual/guardian must obtain confirmation of their diagnosis on a 450B form signed by their physician within 21 days from date of letter
- The individual/guardian has 60 days to apply for/obtain Medicaid when the individual does not yet have Medicaid coverage
- If the individual already has Medicaid coverage, but the Aid Category to which the individual's Medicaid eligibility has been assigned is not compatible with waiver program requirements, he or she has 30 days from the date on the contact letter from BDDS to request that the DFR process the needed change in Medicaid Aid Category
- The individual/guardian must cooperate fully with requests related to the application for Medicaid eligibility and/or any needed change in Medicaid Aid Category

Once all assessments have been made and criteria met, a referral is made to contracting case management entity to interview and choose a permanent case manager, choose a provider, complete the service planning process, and submit a CCB for waiver service.

From the date of contact with the State's contracting of case management:

- Individual/guardian has five (5) days to interview and choose a permanent case manager
- Individual/guardian has 14 days to interview and choose, at minimum, one provider

From the date a provider is chosen:

- Individual/guardian has 14 days to complete the service planning process and submit a CCB
- Once CCB is completed, consumer has three (3) days to review and sign service planning documents

If the individual is unable to start waiver services within the given timeframes, the individual may be removed from the targeting process.

Section 5.6: Initial Plan of Care/Cost Comparison Budget (CCB) Development

The Plan of Care/Cost Comparison Budget (CCB) is developed based upon the outcomes of the initial, annual or subsequent meeting of the Individualized Support Team during which the Person-Centered Plan and the Individualized Support Plan are developed. This entire process is driven by the individual/participant and is designed to recognize the participant's needs and desires. The Case Manager holds a series of structured conversations, beginning with the participant/ guardian and with other individuals, identified by the participant that know them well and can provide pertinent information about them, to gather initial information to support

the person-centered planning process. The overall emphasis of the conversations will be to derive what is important to and what is important for the participant, with a goal of presenting a good balance of the two. The case manager facilitates the IST meeting, reviews the participant's desired outcomes, their health and safety needs and their preferences, and reviews covered services, other sources of services and support (paid and unpaid) and the budget development process using the objective based allocation for waiver services. The case manager then finalizes the ISP and completes the CCB.

Coordination of Waiver Services and other services is completed by the Case Manager. Within 30 days of implementation of the plan, the Case Manager is responsible for ensuring that all identified services and supports have been implemented as identified in the Individualized Support Plan and the CCB. The Case Manager is responsible for monitoring and coordinating services on an ongoing basis and is required to record a weekly case note for each participant. A formal 90 day review is also completed by the case manager with the participant and includes the IST.

Each waiver provider is required to submit a monthly or quarterly report summarizing the level of support provided to the participant based upon the identified supports and services in the Individualized Support Plan and the Cost Comparison Budget. The Case Manager reviews these reports for consistency with the ISP and CCB and works with providers as needed to address findings from this review.

Section 5.7: State Authorization of the Initial CCB

The Case Manager will transmit the Plan of Care/Cost Comparison Budget (CCB) electronically to the State's Waiver Specialist who will review the CCB and Service Planner and confirm the following:

- The individual is a current Medicaid recipient within one of the following categories
    - Aged **(MA A)**
    - Blind **(MA B)**
    - Low Income Families **(MA C)**
    - Disabled **(MA D)**
    - Disabled Worker **(MA DW)**
    - Children receiving Adoption Assistance or Children receiving Federal Foster Care Payments under Title IV E - Sec. 1902(a)(10)(A)(i)(I) of the Act **(MA 4 & MA 8)**
    - Children receiving adoption assistance under a state adoption agreement - Sec 1902(a)(10)(A)(ii)(VIII) **(MA 8)**
    - Independent Foster Care Adolescents – Sec 1902(a)(10)(A)(ii)(XVII) **(MA 14)**
    - Children Under Age 1 – Sec 1902(a)(10)(A)(i)(IV) **(MA Y)**
    - Children Age 1-5 - Sec 1902(a)(10)(A)(i)(VI) **(MA Z)**
    - Children Age 1 through 18 - Sec 1902(a)(10)(A)(i)(VII) **(MA 9 & MA 2)**
    - Transitional Medical Assistance – Sec 1925 of the Act **(MA F)**

- Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121 **(MA U)**

- The individual has a current ICF/MR level of care approval (and, if applying for the Autism Waiver, a formal diagnosis of within the Autism Spectrum is required)
- The individual has been targeted for an available waiver slot;
- The individual's indentified needs will be met and health and safety will be assured;
- That if the total cost of Medicaid waiver and regular Medicaid State plan services for the individual exceeds the total costs of serving an individual with similar needs in an ICF/MR facility, the programmatic cost-effectiveness will be maintained;
- The individual or guardian has signed, indicating acceptance of, the CCB; signed that he/she has been offered choice of certified waiver service providers; and signed that he/she has chosen waiver services over services in an institution.

The Waiver Specialist may request additional information from the Case Manager to assist in reviewing the CCB.

If the Waiver Specialist approves the Initial CCB, the Initial approval letter and Notice of Action are electronically transmitted to the Case Manager, BDDS (for Initials and Annuals only) and Service Providers. Within three (3) calendar days of receiving the Initial CCB approval letter, the Case Manager must print a Notice of Action form (HCBS Form 5) and sign it. The Case Manager must provide copies of the approval letter, the signed Notice of Action form and Addendum (containing information from the CCB and Person Centered Service Planner) to the individual participant/guardian. The participant's chosen waiver service providers are required to register so that they receive the Notices of Action and the Addendums electronically.

The Notice of Action serves as the official authorization for service delivery and reimbursement.

If the Waiver Specialist approves the CCB pending Medicaid eligibility or change of Aid Category, disenrollment of a child from Hoosier Healthwise, facility discharge, or other reasons, the pending approval letter is to be transmitted to the Case Manager, BDDS and Service Providers. The Case Manager must notify the individual or guardian within three (3) calendar days of receipt of the pending approval and provide a copy of the Initial approval letter naming the pending conditions. No Notice of Action is generated until all pending issues are resolved and a final approval letter is released.

If the Waiver Specialist denies the Initial CCB, a denial letter must be transmitted to the Case Manager, BDDS (for Initials and Annuals only) and Service Providers. Within three (3) calendar days of receipt of the denial the Case Manager must complete and provide a copy of a Notice of Action (HCBS Form 5), the Appeal Rights as an HCBS Waiver Services Recipient, and an explanation of the decision to deny to the individual participant/guardian. The case manager

will discuss other service options with the individual and guardian and the individual's name should be removed from the waiting list, unless the individual participant or guardian files an appeal.

NOTE: *Once waiver services begin, waiver participants are sometimes referred to as consumers.*

Section 5.8: Initial Service Plan Implementation

An individual cannot begin waiver services prior to the approval of the Initial Plan of Care/Cost Comparison Budget (CCB) by the State's Waiver Specialist. The Initial CCB represents the service plan identified for the individual as the result of the person-centered description and the individualized support plan development process. If the Waiver Specialist issues an Initial approval letter pending certain conditions being met, those conditions must be resolved prior to the start of the individual's waiver services. If the individual's Medicaid eligibility is approved pending waiver approval, the Case Manager will notify the local DFR Caseworker when the waiver has been approved. The DFR Caseworker and contracting Case Manager coordinate the Medicaid eligibility date and waiver start date. If Medicaid eligibility depends on eligibility for the waiver, the Medicaid start date is usually the first day of the month following approval of the CCB.

If an individual is a Hoosier Healthwise or Medicaid managed care program participant other than Care Select, the Case Manager must contact the local DFR Caseworker to coordinate the managed care program stop date and waiver services start date. Individuals receiving the Indiana Health Care Hospice benefit do not have to disenroll from this benefit to receive waiver services that are not related to the terminal condition and are not duplicative of hospice care. If applicable, the Case Manager and managed care benefit advocate must inform the individual and individual's parent or guardian of his/her options to assure he/she makes an informed choice.

When the CCB is approved by the Waiver Specialist pending facility discharge, the waiver start date can be the same day that the individual is discharged from the facility.

Following discharge from the facility and within three (3) calendar days after the individual begins waiver services, the Case Manager must complete the Confirmation of Waiver Start form in the INsite database and electronically transmit it to the State through the DDRS INsite database.

For all waiver starts, when the Case Manager completes the *Confirmation of Waiver Start* form in the Insite database and electronically transmits it to the DDRS database, the Office of Medicaid Policy and Planning (OMPP) will also be electronically notified to enter the individual's waiver start information in the Indiana AIM database.

When the *Confirmation of Waiver Start* form is received electronically by DDRS, the form is reviewed and, if accepted, an approval letter will be automatically transmitted back to the Case Manager. The period covered by the Initial CCB will be from the effective date of the *Confirmation* form through the end date of the Initial CCB that was previously approved by the Waiver Specialist.

Within three (3) calendar days of receiving the Initial CCB approval letter, the Case Manager must print a Notice of Action form (HCBS Form 5) and sign it. The Case Manager must provide copies of the signed Notice of Action form and Addendum (containing information from the CCB and Person Centered Service Planner) to the individual/guardian. The individual's chosen waiver service providers are required to register so that they receive the Notices of Action and the Addendums electronically.

There is no reimbursement for services delivered prior to receipt of the Notice of Action.